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Institute of Medicine
Committee on Public Financing and Delivery of HIV Care
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Briefing Points

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1. Introduction

2. Purpose of Presentation

   A. Discuss *environmental* impediments to planning and financing HIV care *systems* at the national, state, local, and organizational levels.

   B. Highlight observations gathered from: (1) almost two decades of work in HIV financing, (2) technical assistance and training activities undertaken across the US, and (3) the results of HRSA-sponsored national consultations with HIV care providers.

3. HIV Care Planning

   A. Simultaneously with HIV planning activities, there are other concurrent planning efforts focused on broader policy and programmatic topics (e.g., Medicaid, substance abuse treatment systems, and mental health systems).

      ▪ Issues related to HIV service delivery and financing are not commonly a major consideration in the planning, design, and implementation of broader public financing.

      ▪ Policy makers must address the needs of many interest groups simultaneously and are reluctant to establish programs or policies solely for HIV infected individuals.

   B. Systemic health care market and economic forces have a significant impact on HIV care and financing (e.g., State budget deficits, health care reform, increasing adoption of managed care systems for employed and publicly insured populations, health care personnel salary structures, nursing shortage, welfare reform).

      ▪ Such systemic policy issues are not within the authority of HIV planning bodies or CARE Act grantees.

      ▪ These issues often are not considered by HIV planning bodies because their specific impact on local HIV infected populations is unclear.

   C. Policymaking and related programmatic design and financing are commonly undertaken by the legislative and regulatory process, by appointed State and federal officials, or by program management staff outside of the community planning environment.

D. Multiple, sometimes poorly coordinated, planning efforts are being undertaken at the national, State, regional, and local levels

- Planning bodies and related activities include: Title I planning councils, care consortia, community prevention, ADAP advisory groups, HIV housing planning groups, Statewide Coordinated Statement of Needs groups, various committees and subcommittees, and public hearings.

- CARE Act providers tend to participate in multiple planning efforts simultaneously.

E. CARE Act grantees and HIV planning bodies tends to focus on needs assessment, priority setting, and procuring funds directly under their authority.

- CARE Act providers report that there is little time, energy, or legal authority to focus on comprehensive systems planning.

- Participation in HIV care planning efforts is reported to be extremely time consuming, politicized, polarizing, of limited direct benefit to the operations of HIV care programs, and distracts care providers from their patient or client responsibilities.

- HIV planning tends to be specific to individual titles, sometimes with poor communication between grantees of various titles.

- HRSA conflict of interest policies sometimes result in inadequate direct representation of medical providers, substance abuse treatment and mental health systems, and other care providers; resulting in a vacuum of their input into the planning process.

- The attendance of representatives from broader systems (e.g., Medicaid, mental health and substance abuse treatment systems, etc.) at planning meetings can be inconsistent.

- Terms limits placed on Planning Council members sometimes results in the loss of expertise and institutional memory.

- With increasing representation of consumers and agencies not receiving CARE Act funds, basic training is necessary in a wide array of topics including basic parliamentary procedures, CARE Act requirements, epidemiology, HIV treatment, needs assessment results, etc. Ongoing staff support is important to ensure that these individuals understand the issues before them.

- Basic timely information needed to address systemic issues commonly may not be available or is focused on specific segments of the HIV infected population, such as individuals already in HIV care systems funded by the CARE Act.

F. HIV care planning results in variable funding for HIV care, therapeutics, case management, housing, and supportive services from community to community.

4. Impact on Providers

   A. Broader health care market and economic forces have had the greatest impact on HIV clinical providers because they are less likely than other HIV providers to be funded for their operating costs by CARE Act funds.

   - Some HIV clinics rely heavily on institutional support for salary support, administrative infrastructure, rent, and other operating costs.

   - The institutions in which HIV clinical programs operate are increasingly experiencing significant budgetary constraints that may impact the resources available to HIV outpatient clinics, infectious disease departments, and other sites in which large numbers of HIV infected patients are receiving care.

   - Among group practices, demands for increased productivity and third party revenue has sometimes resulted in substantial pressure on individual clinicians whose HIV infected patients require significantly longer and more intensive visits than other patients.

   - Clinical research funds, historically used by HIV outpatient clinics to support clinical salaries, may not available or is no longer a significant portion of clinics' operating budgets.

   - Public and commercial third party fee-for-service rates and sub-capitated contractual arrangements often do not cover operating costs of HIV outpatient departments, community clinics, or clinicians in private practice.

     a. The significantly growing intensity and length of routine HIV primary and specialty visits are not reflected in standard insurance payment systems.

     b. A wide array of services commonly provided in HIV clinical settings are not covered by third party payers (e.g., treatment adherence counseling, medication education, telephone consultation time with community physicians, medical documentation preparation for disability applications).

   - Clinics and providers increasingly must address and adapt to widely divergent payment structures, benefit coverage policies, annual and lifetime benefits ceilings, prior authorization policies, and eligibility determination processes.

     a. As their patients enroll and disenroll in various insurance systems, coverage may fluctuate significantly and result in gaps in coverage for essential HIV therapeutics, laboratory testing, etc.

   - External health care market and economic forces are sometimes compounded in some communities by limited allocation of CARE Act funds for HIV primary care and specialty services.

     a. Without grant funds for salaries and other operating costs, clinical providers sometimes do not have a financial cushion to soften the impact of inadequate third party insurance payments.

- The majority of HIV primary care and specialty care programs responding to a national consultation report that they do not have sufficient funding to meet the needs of their current patient load. Their capacity to meet the needs of their current patient loads are impacted by the need for additional clinical and non-clinical personnel, inadequate clinical space, and other resources.

B. Among clinical providers receiving CARE Act funds, a number of structural challenges are reported.

- The application process for CARE Act funds tends to be labor intensive, not supported by institutional operating budgets, and can divert time away from the providing care.

- Among HIV clinics that receive CARE Act funds, the administrative cap set by HRSA for most titles of the CARE Act is reported to be too low to sufficiently cover the administrative cost of operating a grant funded program.

C. The patients served by HIV clinical providers are more likely than other CARE Act providers to have insurance that covers their services. Therefore, clinical providers may be more likely to be impacted by HRSA's policy regarding payer of last resort.

- HRSA has made an effort to provide grantees with some flexibility regarding implementation of the payer of last resort policy.

- There is variability in the interpretation of that policy and general confusion among grantees that may result in significantly reduced access to CARE Act funds for HIV primary and specialty care in some communities.

- HIV clinics and practices may be reluctant to communicate their financial problems to HIV planning bodies because they do not want to alarm their patients, be seen by their institutions as rocking the boat, or are too embarrassed to acknowledge their solvency problems.

- Since HIV clinicians increasingly do not participate in the HIV planning process, the growing financial crisis in HIV care is not well know, poorly understood, or dismissed as being a ploy to grab CARE Act funds from social support providers who do not have access to third party revenue.

5. Despite these significant barriers, successful HIV planning and financing efforts have been launched across the US.

A. Examples include: HIV capitated programs, enhanced reimbursement and capitated payment structures, Medicaid eligibility expansions, carved in services, carved out services, integrated service systems, data pooling, joint decision making, and joint procurement.

6. What are the key elements to making HIV care planning and financing efforts successful?

A. Community HIV advocacy has been very important in the past, but is increasingly difficult to sustain.

B. A sufficiently large HIV epidemic within a community or insured population commonly results in making HIV infected individuals an important and compelling group whose needs must be met by policymakers.

C. Visionary leadership among policy makers, grantees, participants in the planning process, and consumers is vital to creating an atmosphere conducive to "thinking outside the box."

- Personal connection to the HIV epidemic has often been an element in the emergence of such leaders.

D. Technical resources and competency are essential to the successful design and financing of new systems.

E. Collaboration rather than competition among the various players is essential.

F. Institutional support is critical to the successful design and financing of HIV care.

- Such support includes being given sufficient resources or being "left alone" to be creative.